BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **LURALIE LEONARD, M.D.** License No. 27818 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-11-0120A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO THE SAME**

Luralie L. Leonard, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 27818 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-11-0120A after receiving a complaint from a physician regarding Respondent's care and treatment of an infant alleging failure to follow NALS protocol resulting in the death of the infant; delivery by cesarean section (C-section) with possible twin-to-twin transfusion syndrome; and failure to perform a blood transfusion for the infant.

4. On January 20, 2011, a set of identical twins at a little less than 36 weeks gestation was delivered. During the course of the mother's prenatal care, multiple fetal ultrasounds showed normal results with no evidence of twin to twin transfusion syndrome. The plan had been to deliver via C-section on January 21, 2011; however, the mother presented a day early and was found to be in active labor.

5. Twin A was delivered via vaginal birth, did well and was discharged three days later.

6. A crash C-section was performed to deliver Twin B after an ultrasound revealed that the baby's position changed from vertex to footling breech and attempts of external cephalic version were unsuccessful. Twin B was born via breech extraction with a tight nuchal cord and was noted to be limp and pale.

7. Following delivery, Twin B was handed off to Respondent. Twin B received positive pressure ventilation and chest compressions immediately after birth and after three minutes, she cried and moved.

8. Twin B was taken to a special care nursery where an umbilical venous catheter was placed. Her vital signs were abnormal and she was noted to be in respiratory distress. Respondent considered transfusing the baby, but was informed that the hospital had no ability to transfuse a newborn.

9. Arrangements were made to transport the infant to Phoenix Children's Hospital where a neonatologist had accepted the patient. Twin B began to have irregular breathing, bradycardia, and apnea. She was intubated with a 2.5 endotracheal tube (ET tube). Respondent was contacted and upon arrival she charted that she heard breath sounds bilaterally.

10. Twin B subsequently sustained three episodes of cardiopulmonary arrest within one hour. During transport, a blood pressure could not be obtained and the infant was noted to be pale and cool.

11. Upon arrival to the hospital. the neonatologist noted that the ET tube was in the esophagus rather than the trachea. Twin B was reintubated with a 3.5 ET tube. Umbilical arterial and venous catheters were placed, and all subsequent arterial blood gases showed severe acidosis. Twin B arrested and required epinephrine, chest

compressions, and NaHCO3. The family agreed to discontinue support and the baby was pronounced shortly thereafter.

12. The standard of care for a newborn with respiratory distress requires a physician to recognize the condition, follow airway, breathing and circulation (ABC) protocol, obtain a blood gas and chest x-ray ASAP, and provide adequate oxygenation and ventilation.

13. Respondent deviated from the standard of care by failing to recognize Twin B's respiratory distress, by failing to follow ABC protocol, by failing to obtain a blood gas ASAP, and by failing to provide adequate ventilation.

14. The standard of care for a newborn with hypovolemic shock requires a physician to recognize the condition, perform a quick physical exam, and restore intravascular volume as quickly as possible.

15. Respondent deviated from the standard of care by failing to recognize that Twin B was in hypovolemic shock and by failing to restore intravascular volume in a timely manner.

16. The standard of care for a critically ill newborn while waiting for transport care requires the referring physician to be in charge of the infant's care, initiate stabilization, identify medical issues, convey medical information to a neonatologist, and intervene when there is a medical crisis.

17. Respondent deviated from the standard of care by accepting the duty of being in charge of the infant's care, but failed to stabilize the baby, failed to recognize that Twin B was critical and failed to aggressively intervene.

18. Respondent's deviations from the standard of care caused Twin B to develop severe acidosis that caused multi-organ failure and death.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 6th day of October, 2011.

ARIZONA MEDICAL BOARD

(SEAL)

By _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges she has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

11. ***Respondent has read and understands the conditions of probation.***

DATED: Sept. 1, 2011

Luralie L. Leonard, M.D.

EXECUTED COPY of the foregoing mailed this 6th day of Oct., 2011 to:

Luralie L. Leonard, M.D
Address of Record

ORIGINAL of the foregoing filed this 6th day of Oct., 2011 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Arizona Medical Board Staff